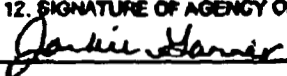
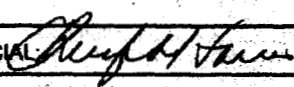


DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATIONFORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER 01-28	2. STATE: ILLINOIS
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE: October 1, 2001	
5. TYPE OF PLAN MATERIAL (Check One) <input type="checkbox"/> NEW STATE PLAN <input checked="" type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input type="checkbox"/> AMENDMENT		
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)		
6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT a. FFY 02 \$ (\$79,100) b. FFY 01 \$ (\$79,100)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19B Supplement 1, page 2	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Attachment 4.19B Supplement 1, page 2 Attachment 4.19B Page 50	
10. SUBJECT OF AMENDMENT: MEDICARE/MEDICAID payments		
11. GOVERNOR'S REVIEW (Check One) <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Not submitted for review by prior approval		
12. SIGNATURE OF AGENCY OFFICIAL: 	16. RETURN TO: ILLINOIS DEPARTMENT OF PUBLIC AID 201 SOUTH GRAND AVENUE, EAST SPRINGFIELD, IL. 62763-0001 ATTENTION: John Rupcich	
13. TYPED NAME: Jackie Garner		
14. TITLE: DIRECTOR		
15. DATE SUBMITTED		

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12/26/01	18. DATE APPROVED: 1/30/02
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Cheryl A. Harris	22. TITLE: Associate Regional Administrator Division of Medicaid and Children's Health
23. REMARKS:	

RECEIVED

DEC 26 2001

DMCH - IL/IN/OH

Revision: HCFA-PM-91-4 (BPD)
January 2002

Supplement 1 to Attachment 4.19-B
Page 2
QMB No.: 0938

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES
OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs:	Part A	<u>SP*</u> Deductibles	<u>SP*</u> Coinsurance
	Part A		<u>Full**</u> Coinsurance
	Part B	<u>SP</u> Deductibles	<u>SP</u> Coinsurance
Other Medicaid Recipients	Part A	<u>SP*</u> Deductibles	<u>SP*</u> Coinsurance
	Part A		<u>Full**</u> Coinsurance
	Part B	<u>SP</u> Deductibles	<u>SP</u> Coinsurance
Dual Eligible (QMB Plus)	Part A	<u>SP*</u> Deductibles	<u>SP*</u> Coinsurance
	Part A		<u>Full**</u> Coinsurance
	Part B	<u>SP</u> Deductibles	<u>SP</u> Coinsurance

*For those title XVII services not otherwise covered by the Title XIX State Plan, the Medicaid agency will establish rates for those services at 80% of the full Medicare allowable charge for use in determining the amount of coinsurance and deductible due the provider.

**Applies to skilled nursing services only.

TN: 01-28
Supersedes
TN: 91-25

Approval Date: 10-01-01 Effective Date: 10-01-01